

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 3 3

2. STATE:

Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.201, 447.302

7. FEDERAL BUDGET IMPACT:

a. FFY 01 \$ 0
b. FFY 02 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 29-36, 38, 39,
and 41-49

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, page 29 (MS-96-39),
page 30 (MS-99-35), page 31 (MS-97-31),
page 32 (MS-96-39), pages 33
through 36 (MS-99-35), pages 38
and 39 (MS-96-39), page 41 (MS-99-35),
pages 42 and 43 (MS-96-39), page 44
(MS-97-31), page 45 (MS-96-39), and
pages 46 through 49 (MS-99-35)

10. SUBJECT OF AMENDMENT:

Change in reimbursement methodology for direct
medical education costs in outpatient hospital
care

11. GOVERNOR'S REVIEW (Check One):

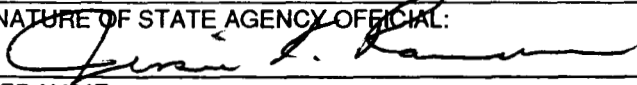
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Jessie K. Rasmussen

14. TITLE:

Director

15. DATE SUBMITTED:

September 6, 2001 9-5-01

16. RETURN TO:

Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

09/06/01

18. DATE APPROVED:

NOV 08 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

AUG 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Nanette Foster Reilly

22. TITLE:

Acting ARA for Medicaid & State Operations

23. REMARKS:

cc:
Rasmussen
Anderson
CO

SPA CONTROL
Date Submitted: 09/06/01
Date Received: 09/10/01

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care****1. Introduction**

Medicaid reimbursement for outpatient hospital care is based on a combination of prospectively set payments based upon Medicaid-determined fee schedules (for noninpatient programs, ambulance, and observation beds), Medicare-determined fee schedules (for stand-alone laboratory services), and cost-based payment methodology based upon ambulatory patient groups (APGs).

Ambulatory patient groups are categories established by HCFA and distributed by 3M Health Information Systems. When reimbursement is based upon APGs, the reimbursement amount is a blend of hospital-specific and statewide average costs reported by each hospital, for the costs associated with routine and ancillary care, per Medicaid outpatient visit.

No special groupings or classifications of providers are established under this reimbursement methodology.

2. Definitions

The following definitions are provided to ensure understanding among all parties.

"Allowable costs" are those defined as allowable in 42 CFR, Chapter IV, Part 405, Subpart D, except for the purposes of rate setting, where only the reported costs of the interns and residents are included in the calculation for direct medical education. Costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only those costs are considered in calculating the Medicaid outpatient reimbursable cost per APG for the purpose of this plan.

"Ambulatory patient group (APG)" means a group of similar outpatient procedures, encounters or ancillary services which are combined based on patient clinical characteristics and expected resource use. Data used to define APGs include ICD-9-CM diagnoses codes and CPT-4 procedure codes.

"Ancillary services" means those tests and procedures ordered by a physician to assist in patient diagnosis or treatment. Ancillary procedures, such as immunizations, increase the time and resources expended during a visit, but do not dominate the visit.

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

APR 01 2001BY 01 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

“APG relative weight” means a number that reflects the expected resource consumption for cases associated with each APG, relative to the average APG. That is, the Iowa-specific weight for a certain APG reflects the relative charge for treating all singleton cases classified in that particular APG, compared to the average charge for treating all Medicaid APGs in Iowa hospitals.

“Assessment payment” means an additional payment made to a hospital for only the initial assessment and determination of medical necessity of a patient, for the purpose of determining if the emergency room is the most appropriate treatment site. This payment is equal to 50 percent of the customary reimbursement rate for CPT-4 code 99281 (evaluation and management of a patient in the emergency room), as of December 31, 1994.

“Base year cost report” means the hospital’s cost report with a fiscal-year-end on or after January 1, 1998, and before January 1, 1999. Cost reports are reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base amount” means the case-mix-adjusted, hospital-specific operating cost per visit associated with treating Medicaid outpatients, plus the statewide average case-mix-adjusted operating cost per Medicaid visit, divided by two. This basic amount is the value to which inflation is added to form a final payment rate.

“Case-mix adjusted” means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.

“Case-mix index” means an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“Consolidation” means the process by which the APG classification system determines whether separate payment is appropriate when a patient is assigned multiple significant-procedure APGs. All significant procedures within a single APG are suppressed (or consolidated) for payment purposes, except one. Multiple, related significant procedures in different APGs are consolidated into the highest weighted APG for reimbursement purposes. Multiple, unrelated significant procedures are not consolidated; thus, each receives separate payment.

State Plan TN No. MS-01-33Superseded TN No. MS-99-35

Effective

Approved

AUG 01 2001NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

"Cost outlier" means a case that has an extraordinarily high cost and thus is eligible for additional payment above and beyond the base APG payment.

"Current Procedural Terminology - Fourth Edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (HCFA 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits. This formula is limited by funding availability that is legislatively appropriated.

"Discounting" means a reduction in the standard payment when multiple procedures or ancillaries are performed during a single visit. Discount rates are defined in Section 10.

"Final payment rate" means the blended base amount that forms the final dollar value used to calculate each provider's reimbursement amount, when multiplied by the APG weight. These dollar values are displayed on the rate table listing.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs associated with the operation of graduate medical education programs.

"Grouper" means the Version 2.0 Grouper software developed by 3M Health Information Systems for HCFA, for payable APGs made to support Medicaid program policy in Iowa.

"Inlier" means a case where the cost of treatment falls within the established cost boundaries of APG payment.

State Plan TN No. MS-01-33

Effective

NOV 01 2001Supersedes TN No. MS-97-31

Approved

NOV 04 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

"International Classification of Diseases - Fourth Edition, Ninth Revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Invalid claims or visits" means claims or visits that are not priced and paid using the ambulatory patient group (APG) system.

"Net number of Iowa Medicaid valid visits" means total visits plus the incremental portion of visits that resulted in outliers less invalid visits.

"Outpatient visit" means those hospital-based outpatient services which are billed on a single UB-92 claim form, and which occur within 72 hours of initiation of service, with exceptions noted in Section 15.

"Packaging" means the inclusion of routinely performed ancillary services in the payment for an APG. In the APG classification system, a list of ancillary services has been developed which are always "packaged" when they occur with a significant procedure or medical visit. Relative weights for these significant procedures and medical visits have been calculated to include the cost of these routine ancillaries. Ancillaries appearing on the "uniform list" are performed for a wide range of visits and are relatively low cost. Incidental procedures, such as venipuncture, are also uniformly packaged.

"Peer review organization (PRO)" means the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room.

"Rate table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate APG weight.

"Rebasing" means the redetermination of the blended base amount from more recent Medicaid cost report data.

"Recalibration" means the adjustment of all APG weights to reflect changes in relative resource consumption.

State Plan TN No. MS-01-33

Superseded TN No. MS-96-39

Effective

Approved

AUG 01 2001

NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

“Risk corridor” means payment limits to prevent immediate large financial gains or losses for Iowa hospitals due to APG implementation.

“Significant-procedure APG” means a procedure which is normally scheduled, which constitutes the reason for the visit, and which dominates the time and resources expended during the visit.

“Singleton APG” means those APGs on a patient claim which, following consolidation of significant procedures and packaging of ancillaries, are part of a visit with no remaining multiple significant procedures. Singletons, as well as medical and ancillary visits, are used to calculate relative weights in the procedure described in Section 7.b.

“Statewide visit expected payment (SVEP)” means the expected payment for an outpatient visit, for use in defining cost outliers. This payment equals the sum of the statewide average case-mix-adjusted operating cost per Medicaid visit multiplied by the relative weight for each valid APG within a visit (following packaging and discounting), which includes the applicable fee schedule amounts.

“Valid claims or visits” means those claims or visits that are priced and paid using the ambulatory patient group (APG) system.

3. Services Covered by APG Payments

Medicaid adopts the Medicare definition of outpatient hospital services, which are covered by the APG-based prospective payment system, except as indicated herein. Claims for outpatient NIP services, ambulance, clinical laboratory, and observation bed stays are not reimbursed through APG payment. (See Section 14 regarding these services.)

Iowa Medicaid does not accept claims for payment for the following APGs, as defined in Version 2.0 of the HCFA-funded development project: APG 005, nail procedures; APG 171, artificial fertilization; APG 212, fitting of contact lenses; APG 386, biofeedback and other training; and APG 382, provision of vision aids.

State Plan TN No.	<u>MS-01-33</u>	Effective	<u>10/01/00</u>
Superseded TN No.	<u>MS-99-35</u>	Approved	<u>10/01/00</u>

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

These services are not services typically provided in an outpatient setting and are often services that are not eligible for payment by Iowa Medicaid or require additional approval, editing, or certification from another source. Upon the provider's request, any service performed that groups into one of the above APGs may be reviewed for appropriateness of payment if the claim has been denied.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per APG and the statewide average cost per APG can be determined by using the individual hospital's 1998 Medicare Cost Report (HCFA 2552), Worksheet OP-1, as submitted to the state. The total numbers of Medicaid visits were determined from the use of submitted claims data.

The base-year cost for the current rebasing is the hospital's 1998 fiscal year end. The rates have been trended forward using inflation indices of 2.8% for SFY 1998, 0.0% for SFY 1999, 2.0% for SFY 2000, 3.0% for SFY 2001, and (3.0%) for SFY 2002.

a. Calculation of Hospital-Specific and Statewide Medicaid Outpatient Visits

The total number of Medicaid outpatient visits was determined as the number of 1998 claims contained in the Medicaid Management Information System:

- Less the number of visits associated with services provided under the NIP programs,
- Less the visits associated with an ambulance claim (if the claim was a single line item),
- Less the visits associated with observation beds (if the claim was a single line item), and
- Less the visit for the provision of referred clinical laboratory testing (if the claim was a singleton claim for a referred test).

The remaining number of visits was then inflated to account for an increased number of eligibles and increased volume of services in accord with state budgetary projections. This number is known as the hospital-specific number of outpatient visits. To arrive at the statewide number of visits, all hospital-specific numbers of visits are summed.

State Plan TN No. MS-01-33Supersedes TN No. MS-99-35

Effective

Approved

AUG 01 2001NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

b. Calculation of Statewide Average (Case-Mix-Adjusted) Cost Per Visit

The statewide average case-mix-adjusted cost per discharge is calculated by taking:

	Statewide total Iowa Medicaid outpatient expenditures
Less	The total dollar expenditures for interns and residents costs, based on all hospitals' base-year cost reports
Less	The calculation of actual, projected payments that will be made for outliers, fee-scheduled clinical laboratory tests, noninpatient programs (see Section 14, part b), ambulance services, and observation beds.
	The remaining amount is case-mix adjusted, then is
Multiplied by	The inflation update factor, and
Divided by	The statewide total net number of valid Medicaid outpatient visits.
The result is:	The statewide average case-mix-adjusted cost per visit.

c. Calculation of Hospital-Specific Case-Mix-Adjusted Average Cost Per Visit

As determined from the 1998 base year cost report, the hospital-specific case-mix adjusted average cost per visit is calculated by taking:

	The lesser of total 1998 Iowa Medicaid costs or covered reasonable charges for each hospital
Less	The actual dollar expenditures for direct medical education costs
Less	The actual dollar costs for outliers, fee-scheduled laboratory tests, and noninpatient programs (see section 14, part b), observation beds, and ambulance
Divided by	The hospital-specific case-mix index
Multiplied by	The inflation update factor
Divided by	The total number of hospital-specific valid Medicaid outpatient visits
Equals	The hospital-specific case-mix-adjusted cost per visit.

State Plan TN No. MS-01-33

Effective

APR 01 2001

Supersedes TN No. MS-99-35

Approved

NOV 08 2000

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****d. Calculation of the Blended Statewide and Hospital-Specific Base Amount**

The APG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts. To arrive at a 50/50 blended base amount, the hospital-specific case-mix-adjusted average cost per visit is added to the case-mix-adjusted statewide average cost per visit, and the total is divided by two.

e. Determination of Final Payment Rate Amount

Each hospital's APG-based payment equals the hospital's blended base amount multiplied by the APG weight.

5. Calculation of the Direct Medical Education Component

The reimbursement for direct medical education is allocated to the Graduate Medical Education and Disproportionate Share Fund and is not paid on a per-claim basis. The requirements to receive payments from the fund, the amount allocated to the fund, and the methodology used to determine the distribution amounts from the fund are found in Section 24.

6. The Inflation Update Index and Annual Update

Inflation of base payment amounts by the Data Resources, Inc., hospital market basket index shall be performed annually, subject to legislative appropriations.

7. Explanation of Iowa-Specific Relative Weights

An APG weight is a relative value associated with the charge for conducting an outpatient procedure or medical visit, as compared to that of the average or mean procedure or visit.

Iowa-specific relative APG weights have been calculated using applicable claims for the period January 1, 1997, through December 31, 1998, paid through March 31, 1999. The calculation includes all normal inlier claims, as well as the inlier portion of cost outlier claims. This second component is known as "trimmed claims."

State Plan TN No. MS-01-33

Effective

AUG 01 2001Supersedes TN No. MS-99-35

Approved

NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

- (4) Relative weights for APGs that had low or no volume in the claims data and weights that were deemed too high or low by a committee of clinicians assembled by the Iowa Foundation for Medical Care are administratively adjusted.
- (5) The relative weights are then normalized, so that the average case has a weight of one.

c. Calculation of the Hospital-Specific Case-Mix Index

The hospital-specific case-mix index is computed by summing the relative weights for each valid occurrence of an APG at that hospital and dividing by the number of valid Medicaid visits for that hospital.

8. Calculation of Hospital-Specific APG Payment

The final payment rate, as defined in Section 4, is used to determine the final payment amount made to a hospital, subject to the discounting, outlier, and direct medical education policies described in this document. The final payment rate is multiplied by the weight associated with each of the patient's assigned APGs.

The product of the final payment rate times the APG weight results in the total dollar reimbursement made to a hospital on a claim basis. This reimbursement amount may be further adjusted according to the policies relating to discounting, packaging, consolidation of APGs, or payment of outlier reimbursement before the actual payment.

9. Discounting Policy

The purpose of reducing standard payment for multiple procedures or ancillaries in a single visit is to encourage efficient provision of these services. The discount factor reflects the fact that fixed costs are reduced for multiple procedures performed in the same setting at the same time. Examples of such fixed costs are operating room charges, anesthesia, and specimen collection.

Claims for multiple medical visits within a 72-hour period and claims for services billed in "batches" (such as dialysis and chemotherapy) are not subject to discounted payment.

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

MS-01-33
MS-96-39

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

Multiple, nonconsolidated significant procedures are paid at 100 percent of the expected APG payment for the procedure with the highest relative weight on that claim, 60 percent of expected APG payment for the next highest weighted procedure on the claim, and 40 percent for the remaining significant procedures.

Multiple nonpackaged laboratory tests within the same APG are paid at 100 percent of the expected APG payment for the first occurrence and 80 percent of expected APG payment for each subsequent occurrence.

Multiple, nonpackaged nonlaboratory ancillaries within the same APG are paid at 100 percent of the expected APG payment for the first APG occurrence, 60 percent of expected APG payment for the second occurrence and 40 percent for the third or more occurrence.

10. Outlier Payment Policy

Additional payment is made for cases meeting Medicaid criteria of cost outliers for each APG. Cases qualify as cost outliers when cost of service in a given case exceeds the cost threshold.

For visits with a "statewide visit expected payment (SVEP)" equal to or between \$150 and \$700, this cost threshold is determined to be two times the statewide average APG-based payment (or SVEP) for that visit. For SVEPs greater than \$700, the outlier cost threshold for a hospital outpatient visit equals the statewide average payment plus \$500. There is no outlier threshold (or additional payment) for hospital visits with a SVEP less than \$150.

Costs are calculated using hospital-specific cost-to-charge ratios determined in the base year cost reports. Additional payment for cost outliers is 60 percent of the excess between the hospital's cost for the visit and the cost threshold established to define cost outliers.

Facilities are paid 100 percent of outlier costs at the time of claim reimbursement. The PRO selects a 10 percent random sample of outlier cases identified on fiscal agent claims data from all Iowa and bordering state hospitals. At least one case every six months per facility will be selected for review, if available.

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

AUG 01 2001NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****11. Recalibration of Iowa-Specific Weights and Recalculation of Base Amounts and Add-ons**

Iowa-specific weights have been computed by using UB-92 charge data submitted by providers for claims between January 1, 1997, and December 31, 1998, paid through March 31, 1999. These APG weights are recalibrated every three years. All hospitals' base amounts are rebased according to this same schedule.

12. Cost Reporting

Each participating provider must file a Medicare Cost Report, or a HCFA-accepted substitute. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the fiscal agent of Iowa within 150 days after the close of the hospital's fiscal year.

13. Incentives

Payment to hospitals using the APG methodology extends the same incentives for efficiency of operations to the outpatient setting which are inherent to the DRG methodology. This system encourages providers to control their operating costs and hence, lower their actual overall costs for Medicaid.

When the covered charge is lower than the hospital's prospective reimbursement rate, the hospital is allowed to keep the difference. When the reverse is true, the hospital will not experience additional payment for that service.

Under 42 CFR 447.321, upper payment limit tests are required to ensure that Medicaid payments made under this plan do not exceed what would be paid for the services furnished by the group of facilities under Medicare payment principles. This applies to rates paid for outpatient services furnished by hospitals within the following categories:

- ◆ State government-owned or operated,
- ◆ Non-state-government-owned or operated, and
- ◆ Privately-owned and operated.

For non-state-government-owned or operated hospitals, aggregate Medicaid payments may not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. This limitation does not apply to Indian Health Services and tribal facilities.

State Plan TN No. MS-01-33Supersedes TN No. MS-99-35

Effective

Approved

AUG 01 2001NOV 05 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

Iowa Medicaid performs these tests on a yearly basis, after receipt of finalized cost reports from the Medicare fiscal intermediaries.

Additionally, under 42 CFR 447.325, Medicaid may not pay more than the prevailing charges, in aggregate, in a locality for comparable services under comparable circumstances. This test is performed on a yearly basis.

14. Exceptions or Exemptions to the Rate Setting Process

There are several exceptions to the rate setting and payment process as described under the APG system, as follows. Costs for these services, when included in the Medicare Cost Report, were extracted from the cost report and not used in the rate setting process.

When applying penalties for fraud or abuse, Medicaid will use principles normally utilized under Medicare principles of reimbursement. If Medicare is silent on any particular issue, generally acceptable accounting principles as deemed permissible by the American Society of Certified Public Accountants (AICPA) will be utilized.

- a. Clinical laboratory services, when performed as a stand-alone procedure (referred in) and specimens collected at another site (such as a physician's office) and transferred in to the hospital for testing will be paid on the basis of a fee schedule and will not be paid on an APG basis.
- b. Noninpatient programs (NIP) are programs that have been identified as needing special certification under Iowa Medicaid. These programs are: mental health, substance abuse, eating disorders, cardiac rehabilitation, pulmonary rehabilitation, diabetic education, pain management, and nutritional counseling. They have been paid using a fee schedule. These programs will continue to be coded as a NIP service and will be reimbursed using the current fee schedule.

A one time per 12-month period emergency psychiatric or substance abuse evaluation is payable under the APG system, but further mental health or substance abuse treatment must be obtained under the NIP program if services are delivered in the outpatient hospital setting.

- c. Ambulance charges will be billed using a HCFA-1500 claim form and will be reimbursed according to current Medicaid ambulance policy.

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

AUG 01 2001

NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

- d. Observation beds charges will be billed using a special code and will be reimbursed on the basis of a prospectively determined rate per observation bed hour.
- e. An assessment payment will always be paid to a provider when the site of the visit is in the emergency room. This assessment payment allows the provider to determine if the emergency room is the most appropriate site for the treatment and allows the provider to refer the patient to another treatment source.
- f. New or expanded services will be reimbursed under whichever outpatient service is provided to the patient. Any and all provisions for certification, notification, and continued stay review, if applicable, will be enforced.

If any hospital wishes to add, delete, or change any services as described under the NIP units, a full program review may be necessary by Iowa Medicaid to ensure adequacy of the program, staffing levels, or settings.

Other state, federal or local regulations may have impact upon the purchase of capital equipment or implementation of any particular program. Medicaid will not certify any program that is found to be inconsistent with state, federal or local restrictions.

- g. No review is necessary to terminate any currently held Medicaid NIP certifications.
- h. In cases where fraud and abuse has been verified, the hospital's payment will be adjusted based upon the service provided. If the hospital's base year payment is subsequently determined to have been set using information that was false or misleading, an appropriate adjustment will be made to the rate, and all resulting overpayments will be recouped.

15. Hospital Billing for 72-Hour Rule and Multiple-Visits Rule

Hospitals shall normally submit a UB-92 claim, with all services occurring within a 72-hour period, for APG reimbursement to the fiscal intermediary after a patient's outpatient "visit" is complete. Payment for outlier costs is determined when the claim is filed with the fiscal agent, as described in Section 10. However, the following exceptions are allowed:

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

NOV 21 2001

NOV 02 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

- a. Bills for multiple visits may be submitted on a single claim for the following services: noninpatient units (substance abuse, pain management, nutritional counseling, diabetic education, pulmonary rehabilitation, cardiac rehabilitation, eating disorders and mental health), physical, occupational and speech therapies, chemotherapy, radiation therapy, and renal dialysis. For these services, each unit of service on the UB-92 claim form will be considered a separate visit.
- b. Bills for multiple medical encounters (for unrelated diagnoses), such as clinic visits, occurring within a 72-hour period shall be submitted on separate UB-92 claim forms in order to generate full APG payment for these encounters. In the case of hospital-based clinics where multiple, unrelated medical visits occur on the same day, an individual claim form will need to be filed for each separate visit.

16. Rate-Setting Processes for Out-of-State Hospitals

APG payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average case-mix adjusted base amount or the Iowa statewide average case-mix adjusted base amount blended with the hospital-specific base amount.

Hospitals that wish to submit a cost report with data for Iowa Medicaid patients only, no less than 120 days before rebasing, will receive a case-mix-adjusted blended base rate using hospital-specific Iowa-only Medicaid data and the Iowa statewide average cost per visit amount. If a hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for reimbursement purposes in Iowa. Reimbursement is an allocated distribution from the Graduate Medical Education and Disproportionate Share Fund.

Hospitals wishing to submit the HCFA 2552 (or HCFA-accepted substitute) cost report must do so within 60 days from the date of patient visit to the Medicaid fiscal agent. Hospitals that elect to submit cost reports for the determination of blended rates must submit new reports to the department's fiscal agent on an annual basis within 150 days of the close of the hospital's fiscal year end. When audited, finalized reports become available from the Medicare intermediary, the facility may submit them to the Iowa Medicaid fiscal agent.

State Plan TN No. MS-01-33

Effective

AUG 01 2001

Supersedes TN No. MS-97-31

Approved

NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****17. Provider Appeals**

In accordance with 42 CFR 447.253(e), Iowa Medicaid is extending the same appeal rights for rate setting in the outpatient setting as in the inpatient setting. Thus, if a provider is dissatisfied with an APG rate determination, that provider may file a written appeal. The appeal must clearly state the nature of the appeal and be supported with all relevant data. The Department of Human Services (DHS) contracts with the Department of Inspections and Appeals (DIA) to conduct appeal hearings. Based upon a proposed decision by DIA, DHS makes a decision and advises the provider accordingly within 120 days.

18. Payment for Outpatient Services Delivered in the Emergency Room

Payment for outpatient services delivered in the emergency room will be based on the following criteria:

- a. All visits to hospital emergency rooms by Medicaid beneficiaries that do not result in inpatient admission shall result in the hospital receiving an assessment payment, at one half of the fee schedule rate of the CPT-4 code 99281, plus the full APG payment for treatment conducted in the emergency room when the condition is defined as emergent. The diagnosis codes used to determine an emergent status are found in the Provider Manual.
- b. For Medicaid beneficiaries participating in the MediPASS Program, 75% of the appropriate APG payment, plus the assessment payment for treatment of nonemergent conditions shall be paid contingent upon documentation of permission or referral from the recipient's primary care physician or verification that the physician was unavailable to provide permission.

Should treatment for nonemergent conditions be provided to MediPASS participants without such documentation, payment shall consist only of the assessment payment.

- c. For Medicaid beneficiaries who are not participating in the MediPASS Program, treatment of nonemergent conditions in the emergency room shall result in the hospital receiving 75% of the full APG payment plus the assessment payment if a referral from a Medicaid participating physician is documented on the claim. If the referral is not documented on the claim, the hospital shall receive 50% of the APG-based payment plus the assessment payment.

State Plan TN No. MS-01-33Supersedes TN No. MS-96-39

Effective

Approved

AUG 01 2001NOV 01 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)**

If the Medicaid beneficiary is assessed in the emergency room, found to be nonemergent, and transferred to receive actual treatment elsewhere, the hospital emergency room shall receive reimbursement for the assessment.

19. Audits

Each participating hospital is subject to a periodic audit of its fiscal and statistical records. The Department has agreements for the exchange of Medicare and Medicaid information with the following Medicare intermediaries in Iowa and surrounding areas:

Cahaba Government Benefits Administrator (Des Moines and Sioux City)
Mutual of Omaha (Omaha, Nebraska)
Riverbend Government Benefits Administrator (Chattanooga, Tennessee)
United Government Services (Milwaukee, Wisconsin)
Blue Cross and Blue Shield of Wisconsin (Madison, Wisconsin)

20. Hospital-Based Physician Cost Component

Medicaid reimbursement regulations require the split billing of all hospital professional services. The professional components of all such bills must be billed on the HCFA-1500 claim form.

Under certain circumstances, Medicare has allowed a facility with an approved teaching program to combine these components when billing for services. If a provider has been approved by Medicare to bill in this manner, Iowa Medicaid also recognizes that the provider may bill in this manner.

21. Recovery of Overpayments

When The Department determines that an outpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider fails to submit a refund or an acceptable response within 30 days, the amount of the overpayment will be withheld from weekly payments to the provider.

State Plan TN No.	<u>MS-01-33</u>	Effective	<u>AUG 01 2001</u>
Supersedes TN No.	<u>MS-99-35</u>	Approved	<u>NOV 08 2001</u>

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****22. Rate Adjustment for Hospital Mergers**

When one or more hospitals merge to form a distinctly different legal entity, the base rate is revised to reflect this new operation. Financial information from the original cost reports and the original rate calculations is added together and averaged to form the new rate for that entity.

23. Implementation of Risk Corridor

For state fiscal year 1998, the state has removed the risk corridor requirement for hospitals in Iowa and those out-of-state facilities who are receiving blended rates based upon the Iowa statewide average and the hospital-specific average rate.

This corridor was implemented for the purpose of allowing hospitals to plan for prospective reimbursement in future years, to avoid large shifts in financing to specific facilities that are possible under a prospective payment system such as APGs, and to protect the state from large shifts in expenditures that could be possible under prospective reimbursement.

The risk corridor requirement ended at the end of state fiscal year 1997. A retrospective cost-based settlement was performed (according to customary Medicare standards and methodology) each year the corridor was in place.

24. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

State Plan TN No.	<u>MS-01-33</u>	Effective	<u>2001 01 01</u>
Supersedes TN No.	<u>MS-99-35</u>	Approved	<u>NOV 08 2001</u>

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****b. Allocation to Fund for Direct Medical Education**

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services for July 1, 2000, through June 30, 2001, is \$2,811,778, subject to legislative appropriations, and for utilization increases described in Section 25.

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

c. Distribution to Qualifying Hospitals for Direct Medical Education

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

- ◆ Multiply the total count of outpatient visits for claims paid from July 1, 1999, through June 30, 2000, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.
- ◆ Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.
- ◆ Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of the count of outpatient visits will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of the count of outpatient visits will be updated by a three-year period effective for payments from the fund for July of every third year.

State Plan TN No. MS-01-33

Effective

AUG 01 2001Supersedes TN No. MS-99-35

Approved

NOV 08 2001

Methods and Standards for Establishing Payment Rates for Other Types of Care**Outpatient Hospital Care (Cont.)****25. Adjustments to the Graduate Medical Education and Disproportionate Share Fund for Changes in Utilization**

Money is added to or subtracted from the Graduate Medical Education and Disproportionate Share Fund when the average monthly Medicaid population deviates from the previous year's averages by greater than 5 percent.

The average annual population (expressed in a monthly total) is determined on June 30 for both the previous and current years by adding the total enrolled population for all respective months from both years' B-1 MARS report and dividing each year's totals by 12.

If the average monthly number of enrolled persons for the current year is found to vary more than 5 percent from the previous year, a PMPM amount is calculated for each component, using the average number of eligibles for the previous year calculated above. An annualized PMPM adjustment is made for each eligible person that is beyond the 5 percent variance.

26. Relationship to Managed Care

Direct medical education payments are reimbursed directly to hospitals. These payments have been deducted from all managed care capitation payments as part of the rate-setting methodology. No additional payments for these components are made to any managed care organizations.

State Plan TN No. MS-01-33

Effective

1001 01 2001Supersedes TN No. MS-99-35

Approved

MAY 08 2001